

COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax • (303) 866-3883 TTY Bill Ritter, Jr., Governor • Joan Henneberry, Executive Director

November 16, 2010

Peter P. Budetti, MD, JD, Deputy Administrator and Director Center for Program Integrity
Centers for Medicare & Medicaid Services
Department of Health and Human Services,
Attention: CMS-2325-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-6028- P

Proposed Rules Medicare, Medicaid and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers

Dear Dr. Budetti:

I am writing to you on behalf of Colorado's single state Medicaid agency, the Department of Health Care Policy and Financing to provide comment related to proposed rule CMS-6028-P Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers under provisions of the Patient Protection and Affordable Care Act of 2010.

Colorado shares the federal interests in ensuring the integrity of the Medicaid and Children's Health Insurance Programs but wishes to ask for clarification on some provisions and to raise concerns about other provisions. In order, Colorado has these specific comments on the proposed regulations:

§424.535 (a)(11) Revocation of enrollment billing and billing privileges in the Medicare program. *Medicaid termination*. Please clarify the process for notifying Medicare of State Medicaid Agency (SMA) action to terminate or revoke Medicaid billing privileges; including timeframes.

§424.570 (a) Moratoria on newly enrolling Medicare providers and suppliers. Temporary moratoria. Please clarify the process CMS will employ for timely notification to the SMA of a moratorium imposition; and whether the process will include advance notice. Colorado also suggests that the rule be clarified to allow a State to complete any provider enrollment initiated prior to a federally-imposed moratorium. Please note Colorado anticipates that a federally-imposed enrollment moratorium will result in increased numbers of appeals at the State level for those providers where a State Medicaid program requires the provider to be Medicare-enrolled as a condition of participation.

§438.6 (c)(5)(vi) Managed Care Contract Requirements. Special contract provisions. Please clarify whether the definition of "network" includes physicians in staff model managed care entities (MCE) such as Kaiser. Please clarify whether "enrolled" as a participating provider requires the provider have actual fee-for-service (FFS) billing and claims payment privileges or if status as a "rendering" provider is sufficient. Please consider adding a paragraph to allow authority for the SMA to document a good cause exemption for circumstances where the SMA has determined that the requirement will jeopardize recipients' access to services.

§447.90 (a) FFP: Conditions related to pending investigations of credible allegations of fraud against the Medicaid program Basis and purpose. Discussions of "investigation" and "credible allegations of fraud" need to defer to state and federal legal definitions of "fraud," and the existing federal regulatory authority and responsibility of State Medicaid Fraud Control Units (MFCU) as the designated investigators of fraud.

§447.90 (b) FFP: Conditions related to pending investigations of credible allegations of fraud against the Medicaid program Denial of FFP. Colorado recommends that §447.90(b)(1) be deleted and that §447.90(b)(2) be renumbered and expanded to include that "good cause" is established if the items or services are furnished as an emergency. Please clarify whether the FFP prohibition extends to the MCE capitation payment if an individual provider in a MCE is under review or investigation. If so, Colorado recommends that "good cause" State discretion be expanded to allow payment to the MCE when an individual network provider is under review or investigation.

§455.2 Program Integrity: Medicaid Definitions. Credible allegation of fraud. The proposed definition "credible allegation of fraud" is in conflict with the stringency of the existing fraud definition cited in §455.2. Colorado suggests CMS limit the term defined to "credible allegation" and delete reference to "fraud" in the allegation definition. Colorado also asks that CMS please clarify whether the term "provider" includes MCEs.

§455.23 (a)(1) Suspension of payments in cases of fraud. Basis for suspension. The proposed framework for mandatory suspension of payments fails to appropriately recognize that 42 CFR §1007.11 designates authority and responsibility to investigate fraud to the State Medicaid Fraud Control Unit (MFCU). State Medicaid Agencies (SMA) review information prior to making referrals to MFCU but those activities do not constitute "investigation." Please revise the language to reflect adherence to the fraud definition, which has not been altered, and revise the payment suspension imposition requirement to align with circumstances that trigger a referral to MFCU. Colorado suggests that failure to align the payment suspension requirement with referrals to MFCU will result in significant numbers of SMA determinations that "good cause" exists to avoid imposing payment suspensions and that there will be a decrease in MFCU referrals overall. Please clarify that any interest accrued on suspended payments to providers is eligible for FFP. Further, Colorado recommends that the "good cause" State discretion include capitation payment to the MCE when an individual network provider is under investigation. Please revise the language to clarify that the "individual or entity" under investigation is the same "individual or entity" subject to the payment suspension. Finally, the proposed language fails to set a time limit for the duration of a suspension of payment. Please revise the language to include a 180-day suspension without the initiation of a SMA recovery action, and that a suspension continues upon initiation of a SMA recovery action.

- §455.23 (b)(2)(v) Suspension of payments in cases of fraud. Notice of suspension. Please revise the language to add that notice to a provider of a payment suspension include information about any state administrative appeal procedures available.
- §455.23 (c)(2) Suspension of payments in cases of fraud. Duration of suspension. Please clarify that the documentation requirements concerning "appeal rights" is regarding whether the provider pursued an appeal and the result of that appeal as relevant to the suspension <u>termination</u>.
- §455.23 (e) Suspension of payments in cases of fraud. Good cause not to suspend payments. Please consider changing the placement of paragraph (e)(3) to the end of the subsection so that the listing of explicitly delineated reasons precedes the catchall of "not in the best interests of the Medicaid Program."
- §455.23 (f) Suspension of payments in cases of fraud. Good cause to suspend payment in part. Please consider changing the placement of paragraph (f)(2) to the end of the subsection so that the listing of explicitly delineated reasons precedes the catchall of "not in the best interests of the Medicaid Program."
- §455.101 PROGRAM INTEGRITY: MEDICAID. Definitions. Termination means Please revise paragraph (2)(ii) to define "eligible professional" and clarify if an eligible professional is something other than a provider.
- §455.104 Disclosure by Medicaid providers and fiscal agents: Information on ownership and control. Colorado is concerned about the level of State resources (staff or funding for contractors) that would be necessary to collect and keep updated the disclosure information required. Colorado strongly recommends that CMS consider opportunities to leverage existing federal databases such as National Provider Identifier (NPI) to capture the required disclosures in a more efficient, uniform manner rather than requiring each State to develop its own mechanism. Also, please clarify whether disclosure requirements apply to enrolled Indian Health Service (IHS) providers and confirm the State's authority to enforce the requirement.
- §455.104 (b) Disclosure by Medicaid providers and fiscal agents: Information on ownership and control. What disclosures must be provided. Colorado recommends the term "address" used in paragraphs (b)(1)(i) and (b)(4) be clarified to explicitly refer to primary business address, every business location address and PO Box address. Also, please revise the language of paragraph (b)(2) to clarify whether the intent is for disclosure a familial relationship between different persons each with ownership or controlling interests in a disclosing entity and also whether the intent is for disclosure of a familial relationship between a person with ownership or controlling interests in a disclosing entity and a person associated with a subcontractor of the disclosing entity.

- §455.410 (b) Enrollment and screening of providers. Please clarify whether "enrolled" as a participating provider requires that the provider have actual fee-for-service (FFS) billing and claims payment privileges or if status as a "rendering" provider is sufficient. Please clarify whether this requirement applies to Indian Health Service (IHS) providers and confirm a State's authority to enforce the enrollment requirement. Please consider allowing an exemption for good cause for circumstances where the SMA has determined that the adhering to the requirement will jeopardize recipients' access to services.
- §455.410 (c)(2) Enrollment and screening of providers. Colorado suggests that it is administratively inefficient, costly and unrealistic for each state to independently confirm provider applicants' screening and enrollment status in another state. Colorado strongly recommends that CMS consider opportunities to leverage existing federal databases such as National Provider Identifier (NPI) and the National Plan and Provider Enumeration System (NPPES) to capture screening and enrollment information in a more efficient, uniform manner rather than requiring each State to develop its own mechanism.
- §455.412 Verification of provider licenses. Colorado suggests that it is administratively inefficient, costly and unrealistic for each state to independently confirm provider applicants' licensing status in another state. Colorado strongly recommends that CMS consider opportunities to leverage existing federal databases such as National Provider Identifier (NPI) and National Plan and Provider Enumeration System (NPPES) to capture the required licensure status data in a more efficient, uniform manner rather than requiring each State to develop its own mechanism.
- §455.416 Termination or denial of enrollment. Colorado suggests that it is administratively inefficient, costly and unrealistic for each state to independently confirm providers' enrollment status or termination history in another state's Medicaid or CHIP program. Colorado strongly recommends that CMS consider opportunities to leverage existing federal databases such as National Provider Identifier (NPI) and National Plan and the Provider Enumeration System (NPPES) to capture the required enrollment status and termination history data in a more efficient, uniform manner rather than requiring each State to develop its own mechanism.
- §455.416 (c) Termination or denial of enrollment. It is a common State statutory requirement or best practice for a provider to form a legal corporation entity unique to the State; please clarify the legal basis for federal enforceability of termination from or denied enrollment into one State's program based upon termination or denial status in another State where the provider and its principals are the same individuals but the "provider" is a separate legally incorporated entity under State law.
- §455.416 (g)(1) Termination or denial of enrollment. Colorado suggests that (g)(1) be revised to state," ... falsified or omitted any information .."
- §455.416 (g)(2) Termination or denial of enrollment. Please clarify the anticipated rigor of the requirement for identity verification under (g)(2) and whether a background check is sufficient.

- §455.432 (a) Site visits. Please revise the language to include that the State may define the periodicity of post-enrollment site visits by established risk level categories. Please confirm the costs for conducting such site visits are allowable under the application fee authorized in 42 CFR §455.460 and clarify whether the fee is designed to cover both the state and federal share of costs.
- §455.434 Criminal background checks. Please confirm that the costs for conducting such criminal background checks are allowable under the application fee authorized in 42 CFR §455.460 and clarify whether the fee is designed to cover both the state share and the federal share of costs.
- §455.436 Federal database checks. Colorado strongly recommends that CMS consider opportunities to leverage existing federal databases such as National Provider Identifier (NPI), the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/ Entities (LEIE), and the Excluded Parties List System (EPLS) into a consolidated repository against which states can match for required enrollment status and termination history data in a more efficient, uniform manner rather than requiring each State to develop its own mechanism.
- §455.400 National Provider Identifier. Colorado suggests that CMS consider the administrative efficiencies that would be gained by associating each provider NPI number with its CLIA number and cross-referencing with the address in the NPPES.
- §455.450 Screening categories for Medicaid providers. Colorado suggests that it is administratively inefficient, costly and unrealistic for each state to independently confirm a provider applicants' licensing status in another state. Colorado strongly recommends that CMS consider opportunities to leverage existing federal databases such as National Provider Identifier (NPI), the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/ Entities (LEIE), and the Excluded Parties List System (EPLS) into a consolidated repository against which states can match for required enrollment status and termination history data in a more efficient, uniform manner rather than requiring each State to develop its own mechanism. Please confirm that the costs for conducting such screening activities are allowable under the application fee authorized in 42 CFR §455.460 and clarify whether the fee is designed to cover both the state share and the federal share of costs.
- §455.460 Application fee. Please clarify whether the application fee may be designed to include current program integrity activities, or whether the State will be expected to track the increased expenditures of PI activities resulting from this regulation separate from historic PI activities. Please confirm whether the application fee is intended to cover both state and federal share of costs.

Additionally, please clarify how the State should record expenditures on necessary MMIS changes to implement the rule, prior to collecting the application fee. The State may have significant MMIS changes to automate provider enrollment to meet the requirements of the regulation. The State recognizes it would need to submit an APD to receive enhanced federal funds at a 90/10 federal match rate for those system costs and then a 75/25 match rate for ongoing MMIS operations. Is it permissible

for the state share and federal share to follow the normal APD and MMIS operating allocation and reporting process on the CMS-64, and have the provider application fee be a separate reduction to expenditures on the CMS-64 or must the fee offset the cost of the MMIS operations prior to making any entry on the CMS-64 to record the MMIS expenditure.

§455.470 Temporary moratoria. Colorado suggests that the rule be clarified to allow a State to complete any provider enrollment initiated prior to a federally-imposed moratorium.

§455.470 (b)(2) Temporary moratoria. Please revise the language in paragraph (b)(2) to clarify the standard against which a SMA will be reviewed in making a determination that the temporary moratorium would not adversely impact beneficiaries' access.

§498.5 (4) APPEALS PROCEDURES FOR DETERMI-NATIONS THAT AFFECT PARTICIPATION IN THE MEDICARE PROGRAM AND FOR DETERMI-NATIONS THAT AFFECT PARTICPATION OF ICFs/MR AND CERTAIN NFs IN THE MEDICAID PROGRAM. Please revise the language of paragraph (4) to include the State Medicaid Agency in the definition of "agency" whose basis for imposing the temporary moratorium is not subject to review.

§1007.9 (c) (1) and (2) State Medicaid Fraud Control Units: Relationship to, and agreement with, the Medicaid agency. Please revise the language of paragraphs (c)(1) and (2) to conform to the suggested revisions to §455.23 recognizing existing definition of fraud and the authority and responsibility of the State MFCU to investigate fraud.

Thank you for the opportunity to provide comment and ask for clarification. Should you have any questions, I can be reached at <u>Barbara.prehmus@state.co.us</u> or via telephone at (303) 866-2991.

Sincerely,

Barbara B. Prehmus, M.P.H.

Federal Policy & Rules Officer

Cc: Ms. Joan Henneberry, Executive Director

Ms. Lorez Meinhold, Director of Health Reform Implementation & Senior Health Policy Analyst, Colorado Governor Bill Ritter, Jr.

Ms. Angela Brice-Smith, Medicaid Program Integrity Group, Center for Program Integrity

Ms. Cynthia Mann, Center for Medicaid, CHIP, Survey & Certification